



June 26, 2009

The Honorable Charles Rangel
Chair
Committee on Ways and Means
United States House of Representatives
Washington, DC 20515

The Honorable Dave Camp
Ranking Member
Committee on Ways and Means
United States House of Representatives
Washington, DC 20515

The Honorable Henry A. Waxman
Chair
Committee on Energy and Commerce
United States House of Representatives
Washington, DC 20515

The Honorable Joe Barton
Ranking Member
Committee on Energy and Commerce
United States House of Representatives
Washington, DC 20515

The Honorable George Miller
Chair
Committee on Education and Labor
United States House of Representatives
Washington, DC 20515

The Honorable Howard “Buck” McKeon
Ranking Member
Committee on Education and Labor
United States House of Representatives
Washington, DC 20515

Dear Chairmen and Ranking Members of the Tri-Committee:

The 45 undersigned nursing organizations would like to commend the work of the House Tri-Committee on the Health Reform Draft Proposal. This proposed legislation represents a movement towards comprehensive and meaningful reform for our nation’s healthcare system. Nurses are a central element in healthcare quality and safety. It is clear that the Tri-Committee recognizes the fundamental need for accessible quality care and understands the contribution nurses will make to ensure the provisions of the bill are implemented. In our comments, we have cited particularly strong sections of the bill where you have truly addressed the concerns of nursing and additional areas where we feel the language could be strengthened.

Division A – TITLE II—WORKFORCE

Subtitle B—Nursing Workforce

Sec. 2221. AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

We appreciate your recognition of the need to expand the nursing workforce, and thank you for your commitment to amend the Title VIII Nursing Workforce Development Programs under the Public Health Service Act. The Nursing Community is pleased to see so many important provisions included in the bill that will help address the growing nursing shortage. We appreciate the inclusion of the definition of the Nurse Managed Health Centers under the Title VIII definitions. Moreover, we applaud the removal of the 10% cap on doctoral traineeships under the Advanced Education Nursing Grant program and the inclusion of special consideration to eligible entities that increase diversity among advanced educated nurses. Thank you for updating the loan provisions under the Title VIII programs and expanding the Loan Repayment Program eligibility to include graduates who commit to serving as nurse faculty for two years.

However, the nurse faculty shortage continues to plague the nursing workforce supply. Last year, nearly 50,000 qualified applicants were turned away from baccalaureate and graduate nursing programs. The number one reason cited by nursing schools was the lack of nursing faculty. **We respectfully request that the committee consider including the individual nurse faculty loan program that was outlined in H.R. 1460, the *Nurses' Higher Education and Loan Repayment Act of 2009* in your proposed legislation.**

To further expand the nursing educational pipeline, we feel that the inclusion of the Capitation Grant program outlined in the *Nurse Education, Expansion, and Development Act of 2009* (H.R. 2043), would further augment the legislation's ability to fully address the needs of our nursing schools, enabling them to expand student capacity. From 1971 to 1978, Congress provided Capitation Grants (formula grants based on the number of students enrolled) to schools of nursing in support of nursing education. These grants had a stabilizing effect on past nursing shortages by addressing the financial obstacles of nursing programs. **Therefore, we feel the Capitation Grant program offered in H.R. 2043 would augment the existing authorities and the revisions made in your bill.**

We are grateful for the Tri-Committee's acknowledgement that career ladder programs support the advancement of ancillary staff to become registered nurses as highlighted in Section 2502 of this bill. Career advancement opportunities and life-long learning help promote a diverse workforce that reflects the nation's population. **The inclusion of bridge-programs for underrepresented nurses to obtain their baccalaureate and/or graduate degree would enhance the Workforce Diversity Grants in Section 821 of the Public Health Service Act. Hence we suggest including the bridge program description provided by the Nursing Community on May 8, 2009 in Subtitle B, Section 2221.**

Much like other federal programs, nursing has advocated strongly for mandatory Title VIII funding. The Nursing Community commends the creation of a Public Health Investment Fund, which will help supplement regular appropriations for the Title VIII programs in addition to other programs of interest. Therefore, we must express our sincere gratitude for this funding. **We suggest that Part H, Section 871(a) be clarified to demonstrate that \$220 million from the Public Health Investment Fund is in addition to discretionary funding. While we appreciate Section 871(b), we firmly believe, based on previous attempts, that a funding methodology designed by a non-federal agency is problematic. We feel the funding should be solely at the discretion of the Secretary.**

Subtitle A—Primary Care Workforce
Sec. 2201. National Health Service Corps.

We would like to thank you for your support of additional funding for the National Health Service Corps (NHSC). The NHSC plays an essential role in bringing primary care services to underserved areas. Many nurse practitioners have benefited from this program, and with enhanced funding, many more will be able to pay for their education and move on to provide needed healthcare services. **We ask that, in report language accompanying this legislation, Congress instruct the Health Resources and Services Administration to return to its original policy to ensure that pediatric nurse practitioners are eligible for NHSC scholarships as well as the loan repayment program.**

Sec. 2213. Training in family medicine, general internal medicine, general pediatrics, geriatrics, and physician assistantship.

According to the American Academy of Nurse Practitioners (NP), there are over 125,000 NPs practicing in the United States today. Of those NPs, 66% serve in at least one primary care setting. Therefore, approximately 82,500 NPs are practicing in primary care. Nurse practitioners widely practice as primary care providers, particularly in underserved and rural areas, with outcomes equivalent to their physician and physician assistant colleagues. NPs are qualified, cost-effective primary care providers serving diverse populations and communities. **Therefore, we believe that the “Primary Care Training and Enhancement” program, under Section 2213 of this bill, should be expanded to explicitly state and include Advanced Practice Registered Nurses (APRNs) such as Nurse Practitioners and Certified Nurse Midwives.**

Division A – TITLE II - AFFORDABLE HEALTH CARE CHOICES

Many patients elect to see a nurse practitioner for their primary care. Although this legislation appears to go to great lengths to preserve that choice, there are a number of sections that many negate that effort. By limiting patient access to physician-only offices, some of the proposed language reduces a patient’s ability to choose nurse practitioners for their primary care needs and inadvertently disenfranchises a significant portion of the population.

Essential Benefits Package Defined (page 24)

We recommend use of the term “healthcare provider” in place of “physician.”

Coverage of Marriage and Family Therapists Services and Mental Health Counselor Services (pages 414, 418-419)

As mentioned above, NPs provide high-quality, cost-effective care. Their services have been proven to be equal to that of their physician colleagues. **Therefore, we recommend including “or nurse practitioner” after “primary care physician.”**

Division B TITLE III—PROMOTING PRIMARY CARE, MENTAL HEALTH SERVICES, AND COORDINATED CARE

Sec. 1301. Accountable Care Organization Pilot Program

The Nursing Community acknowledges the creation of the Accountable Care Organization (ACOs) pilot program in Title III, Section 1301. We want to ensure the services of APRNs are recognized in payment systems and included in oversight panels charged with the development and evaluation of ACO pilot projects and payment reforms. APRNs play a valuable role in cutting cost while providing quality health care. Nurse practitioners widely practice as primary care providers, particularly in underserved and rural areas, with outcomes equivalent to their physician and physician assistant colleagues. In addition, Certified Registered Nurse Anesthetists (CRNAs) are the primary anesthesia providers in rural America, enabling healthcare facilities in these medically underserved areas to offer obstetrical, surgical, and trauma stabilization services. In some states, CRNAs are the sole providers in nearly 100 percent of the rural hospitals. **We urge the addition of “Advanced Practice Registered Nurse” anywhere in this section where “physician” appears to ensure that APRNs are able to participate in Accountable Care Organization Pilot Programs. In addition, we would ask that Congress include report language to instruct the Secretary to include APRNs explicitly in specifications, as ordered by this legislation in Section (b)(1)(C).**

Sec. 1302. Medical Home Pilot Program

APRN expertise and education, which emphasizes patient and family-centered care, makes them particularly well-suited providers to head the Medical Home Model. We are grateful to the Tri-Committee Panels for the inclusion of nurse practitioners in the Medical Home pilot programs proposed in this legislation. We feel strongly that Medical Home is a necessary part of primary care reform and that nurse practitioners, in particular, are uniquely equipped to handle the demands of a care coordination model that focuses on the patient first. **The Nursing Community is thrilled to see the inclusion of NPs as leaders of the Patient Centered and Community Based Medical Home Model under section 1302 of your bill.**

Division B TITLE IV—QUALITY

Subtitle A—Comparative Effectiveness Research

Sec. 1401. Comparative effectiveness research.

Comparative effectiveness research is critical to the delivery of quality and effective care. We commend the creation of a Center for Comparative Effectiveness Research at the Agency for Healthcare Research and Quality in Section 1401 of the proposed legislation. **While we agree that exploring themes related to prevention, diagnosis, treatment, and management is important, comparative effectiveness research topics would be augmented by investigating comparisons of systems and outcomes by type of provider.**

Nurses are a central to the implementation and delivery safe, quality healthcare. The Tri-Committee clearly recognizes the fundamental need for accessible quality care and understands the contribution nurses will make to ensure the provisions of the bill are implemented. We encourage the use of a standardized data framework for electronic collection of data by nurses in hospitals, ambulatory surgical centers, as well as community and public health settings that utilize standardized terminology and believe that nursing-sensitive measures should be collected as a part of the key health indicators. We concur that the key health indicators should be publicly released.

Division B TITLE VI – PROGRAM INTEGRITY

Subtitle C—Enhanced Program and Provider Protections

Sec. 1639. Face to face encounter with patient required before physician may certify eligibility for home health services under Medicare.

As written, the home health services provisions will, unintentionally add a tremendous cost to this health reform proposal because physicians who would otherwise perform the perfunctory, and unnecessary, task of signing-off on a nurse practitioner’s recommendation for home health, will now have to schedule and charge for a face-to-face encounter with a patient who has already been deemed eligible for home health services by a qualified provider. These suggested changes both remedy an antiquated policy that prevents nurse practitioners from ordering home health, and allow nurse practitioners to fulfill the requirements imposed by this section. **We urge the committee to add “or nurse practitioner” following “physician” wherever the word physician appears in section 1639.**

Division B TITLE VIII—MEDICAID AND CHIP

Sec. 1844. Payments for graduate medical education.

Graduate Medical Education

Section 1844 of the draft legislation revises the information collected for Graduate Medical Education payments. We would like to suggest **that Medicare funding for graduate nursing education, specifically for Advanced Practice Registered Nurses (APRNs) be included in this section.** In hospitals, the vast majority of care is provided by nurses, yet nurses receive little federal funding for clinical training. Unlike the Graduate Medical Education program that has been the primary vehicle for physician training in hospitals over the last 40 years, nursing education programs have not had the support or the funding to sufficiently provide nurses with the training needed for the complex healthcare environment. Because of the critical role nurses play in quality care and patient safety, nursing clinical education should be viewed with the same importance as medicine when reshaping healthcare and moving toward system-wide reform.

Transitional Care Model

The Nursing Community understands the critical role that nurses play in the coordination of care and how that role continues to grow with the maturation of the burgeoning Baby Boom Generation and the need for a coordinated transition from the acute hospital setting into the home, nursing facility, or rehabilitation centers. **We respectfully ask that the language of H.R. 2773, the Medicare Transitional Care Act of 2009 be included as part of this legislative effort.** The Transitional Care (TCM) model, which was developed by the University of Pennsylvania, has shown, through randomized clinical trials, that there were significant health outcomes achieved, reductions in healthcare costs among chronically ill older adults, and increased patient satisfaction. Its application to the most vulnerable of patient groups will provide needed continuity of care and cost savings for those patients most at-risk.

Division C TITLE XXXI—PREVENTION AND WELLNESS

Improving the health of the nation requires collaboration of the entire nation and health professionals. We commend the excellent work of the Tri-Committee to highlight the need for prevention and a strong public health system. The expansion of community health centers, the creation of community-based programs to deliver prevention and wellness services, as well as funds to strengthen local, state, tribal, and territorial public health departments and programs are critical to creating a healthcare system focused on “well-care.” **Public health nurses and advanced public health nurses will play a key role in developing and coordinating these programs and providing essential services.**

Division A, B, and C

Request for Patients’ Access to Care Through Provider Nondiscrimination

Health reform legislation can be strengthened by including language that ensures health plans incorporate a policy of nondiscrimination among qualified licensed providers. When plans limit patients’ access to whole categories of healthcare professionals such as Certified Registered Nurse Anesthetists (CRNAs) by licensure, costs rise and patients’ choices and access to care are limited. For example, in Pennsylvania, the Medicaid program denies reimbursement for services delivered solely by CRNAs (i.e., services that are not medically directed by a physician), when in fact Medicare regards medically directed services (42 CFR §415.110) as being a payment model only and

not a quality of care standard (63 FR 58813, 58842-3, 11/2/1998)). **Health insurance market reforms should support patients' interests and incorporate nondiscrimination policies among qualified licensed providers.** Below is possible language to include in the draft legislation.

“SEC. __. PROHIBITION ON DISCRIMINATION AGAINST HEALTH CARE PROVIDERS. Notwithstanding any other provision of this Act (or an amendment made by this Act), a health insurer to which this Act (or amendment) applies shall not discriminate with respect to participation, reimbursement, covered services or indemnification under a health plan or other health insurance coverage against a health care provider who is acting within the scope of that provider's license or certification under applicable State law. This Act (or amendment) is not intended to require that a health insurer contract with any health care provider willing to abide by the terms and conditions for participation established by the insurer.”

Request for Nurse-Managed Health Clinic Grant Program

Nurse-managed health clinics strengthen access to primary care. By incorporating language expanding grant funding for nurse-managed health clinics, the Tri-Committee can support nurse practitioners in their work to provide high-quality, easily accessed, and cost-effective primary care services. **The Nursing Community respectfully requests that the Tri-Committee consider incorporating language from the *Nurse-Managed Health Clinic Investment Act of 2009 (H.R. 2754)*.**

In conclusion, the draft legislation offers numerous programs that would enhance the nursing workforce for the benefit of the nation's health. We would like to reiterate our appreciation to the Tri-Committee for their significant efforts to draft this important legislation that will seek to address healthcare disparities as well as the primary care, prevention, and nursing needs of not only our underserved populations, but the entire nation. The Nursing Community looks forward to working further with the Tri-Committee to address the concerns raised above, and to support your efforts to achieve meaningful, comprehensive reform of our nation's healthcare system.

Sincerely,

Academy of Medical-Surgical Nurses
American Academy of Ambulatory Care Nursing
American Academy of Nurse Practitioners
American Academy of Nursing
American Association of Colleges of Nursing
American Association of Nurse Anesthetists
American Association of Occupational Health Nurses
American College of Nurse Practitioners
American College of Nurse-Midwives
American Nephrology Nurses' Association
American Nurses Association
American Organization of Nurse Executives
American Psychiatric Nurses Association
American Public Health Association, Public Health Nursing Section
American Society for Pain Management Nursing
American Society of PeriAnesthesia Nurses

Association of Community Health Nursing Educators
Association of Nurses in AIDS Care
Association of PeriOperative Registered Nurses
Association of State and Territorial Directors of Nursing
Association of Women's Health, Obstetric and Neonatal Nurses
Dermatology Nurses' Association
Gerontological Advanced Practice Nurses Association
Hospice and Palliative Nurses Association
Infusion Nurses Society
International Nurses Society on Addictions
International Society of Psychiatric Mental Health Nurses
National Alaska Native American Indian Nurses Association's
National Association of Clinical Nurse Specialists
National Association of Hispanic Nurses
National Association of Neonatal Nurse Practitioners
National Association of Nurse Practitioners in Women's Health
National Association of Pediatric Nurse Practitioners
National Association of Registered Nurse First Assistants
National Black Nurses Association
National Coalition of Ethnic Minority Nurse Associations
National Nursing Centers Consortium
National Organization of Nurse Practitioner Faculties
Nurses Organization of Veterans Affairs
Philippine Nurses Association of America, Inc
Preventive Cardiovascular Nurses Association
Quad Council of Public Health Nursing Organizations
RN First Assistants Policy & Advocacy Coalition
Society of Urologic Nurses and Associates
Wound Ostomy and Continence Nurses Society